WESTSIDE FAMILY HEALTH CENTER
a californiahealth center

MEDICAL AND DENTAL HEALTH HISTORY FORM

To the parents/guardians: Please note we may ask follow-up questions to make sure we have all the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: _____ First Name _____ Middle Name _____

Preferred Name: _____

Date of Birth: / / Gender: Sex assigned at birth:

Pediatric Patient Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Emergency Contact Name: Relation:

Emergency Contact Phone:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had?

[ ] A cough that's lasted longer than three weeks [ ] A cough that produces blood [ ] Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S MEDICAL AND SURGICAL HEALTH HISTORY

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

[ ]ADD/ADHD
[ ]Anxiety
[ ]Anemia
[ ]Arthritis
[ ]Asthma
[ ]Bladder problems
[ ]Bleeding disorders
[ ]Bone/Joint issues
[ ]Cancer
[ ]Cerebral Palsy
[ ]Chicken Pox
[ ]Chronic sinusitis
[ ]Depression
[ ]Diabetes
[ ]Epilepsy
[ ]Fainting
[ ]Growth problems
[ ]Hearing problems
[ ]Heart Issue
[ ]Heart Murmur
[ ]Hepatitis (A,B,C) circle one HIV/AIDS
[ ]Immunizations
[ ]Kidney problems
[ ]Liver problems
[ ]Measles
[ ]Mononucleosis
[ ]Mumps
[ ]Pregnancy
[ ]Rheumatic Fever
[ ]Seizures
[ ]Sexually transmitted infection (STI)
[ ]Sickle Cell Anemia
[ ]Thyroid issues
[ ]Tobacco/Vaping
[ ]Tuberculosis
[ ]Other: _____
_____

Please use an "X" to mark your answers to the following questions Yes No?

Is the patient pregnant or lactating? [ ]Yes [ ]No

Has the patient ever had surgery? [ ]Yes [ ]No If yes, when and what type?

Has the patient ever been hospitalized? [ ]Yes [ ]No If yes, when and why?

Has the patient ever been given a general anesthetic? [ ]Yes [ ]No

Has the patient ever had a blood transfusion? [ ]Yes [ ]No

Does the patient experience excessive bleeding when cut? [ ]Yes [ ]No

Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? [ ]Yes [ ]No
If so, please explain why and provide the name of the doctor making that recommendation.
Doctor's Name: Phone:

Does the patient have any genetic (inherited) conditions? [ ]Yes [ ]No If yes, please explain

Does the patient have any speech difficulties? [ ]Yes [ ]No If yes, please explain

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PATIENT'S FAMILY HISTORY

Has anyone in your family had trouble with the following?
Include mother (M), father (F), brother (B), sister (S), grandmother (GM), grandfather (GF)

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

[ ] Cancer_____ [ ] Heart attack_____ [ ] High cholesterol_____ [ ] Thyroid disease_____
[ ] Depression_____ [ ] Heart disease_____ [ ] Stroke_____ [ ] Other: _____
[ ] Diabetes_____ [ ] High blood pressure_____ [ ] Seizures_____

Please list any other significant family history we should know about:

_____

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions.
Yes No?

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?
[ ]Yes [ ]No If yes, please list them here: _____

Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?
[ ]Yes [ ]No If yes, please list those medications and what happened when the patient took them:_____

Does the patient have other allergies, such as latex, metals, iodine, certain foods, animals, plants, etc.?
[ ]Yes [ ]No If yes, please describe the allergy and the reaction: _____

SOCIAL HISTORY

Please use an "X" to mark your answers to the following questions.
Yes No?

Have you had more than one sexual partner this year? [ ]Yes [ ]No

How many sexual partners have you had in the last year? Male#_____ Female#_____

Did you have unprotected intercourse with your last partner? [ ]Yes [ ]No

Have you ever had a sexually transmitted infection? [ ]Yes [ ]No If yes, when and what kind?_____

What method of birth control are you currently using? _____

Do you smoke cigarettes? [ ]Yes [ ]No If yes, how many cigarettes per day?_____ How long?_____

Do you drink alcoholic beverages? [ ]Yes [ ]No If yes, how many drinks per day?_____Drinks per week?_____How long?_____

Have you ever had a problem with substance abuse? [ ]Yes [ ]No If yes, when?_____

Have you and/or your partner ever used IV drugs? [ ]Yes [ ]No If yes, when?_____

Do you frequently or regularly go on a diet to gain or lose weight? [ ]Yes [ ]No If yes, how often?_____

Do you exercise regularly? [ ]Yes [ ]No If yes, how?_____How often?_____

Have you ever been physically, sexually, or verbally abused by an intimate partner? [ ]Yes [ ]No

List any additional information you feel is important for us to know_____

_____

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PATIENT'S DENTAL HEALTH HISTORY
How would you describe the patient's oral health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor
Does the patient currently have any dental pain or discomfort? [ ] Yes [ ] No If yes, where?
Has the patient ever visited a dentist in the past? [ ] Yes [ ] No If yes, when was the patient's last dental exam?____What was done at that appointment?_____
When was the last time the patient had dental x-rays taken?
Does the patient play any contact sports or participate in active recreational activities? [ ] Yes [ ] No
Have you had any problems with dental treatment in the past? [ ] Yes [ ] No
Have you ever had a reaction to dental anesthesia? [ ]Yes [ ]No
History of brushing:_____ times / day , with _____ toothpaste.
History of Flossing: _____ times/day. Do you clean your tongue ? [ ] Yes [ ] No
Do you have a dry mouth? [ ] Yes [ ] No
Do your gums bleed? [ ] Yes [ ] No
Have you ever had trauma to your mouth or head? [ ] Yes [ ] No
Do you have jaw pain? [ ] Yes [ ] No
Do you grind your teeth? [ ] Yes [ ] No
Are you under stress or have anxiety? [ ] Yes [ ] No
Do you have ulcers or soars? [ ] Yes [ ] No If yes, where?
Are your teeth sensitive? [ ] Yes [ ] No
Do you like your smile? [ ] Yes [ ] No How would you like to improve it?
Do you like going to the dentist? [ ] Yes [ ] No

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NOTE: I understand that it's important for both the provider and the patient or his/her guardian to talk honestly about the patient's health before treatment starts. I have answered all of the questions above completely and accurately. I understand that the provider(s) and his/her staff need this information, so the patient receives the right kind of care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The provider and I have talked about any questions I had about this form.
I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Patient/Parent/Legal Guardian:_____ Date:_____

FOR COMPLETION BY MEDICAL/DENTAL PROVIDER

Comments: _____

Office Use Only:

[ ] Medical Alert [ ] Premedication [ ] Allergies [ ] Anesthesia

Reviewed by:_____ Date: _____